

Mental health consequences of war: gender specific issues

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Modern warfare targets civilian populations. We are experiencing a significant increase in the percentage of civilian deaths among those killed in a war, and up to 90% of casualties today are civilians (1). In their review, Murthy and Lakshminarayana state that “women have an increased vulnerability to the psychological consequences of war”. Indeed, women and men are exposed to different traumata in times of war. They may exhibit different psychological problems, cope in different ways, and have different thresholds for entering treatment. Thus, the gender perspective is both challenging and needed.

War creates acute and long-lasting health problems in men and women, but many aspects of war affect the health of women disproportionately,

through societal changes that may subordinate them and not prioritize their life and health (2). In areas of war and conflict, women are more likely to face the threats of community violence outside the home (3). As mentioned by Murthy and Lakshminarayana, women may experience violent acts, as seen in recent conflicts, including those in the Darfur region of Sudan and in Iraq.

There is increasing recognition by international organizations of the particular risks that women face in refugee camps (4,5). Women who seek shelter from the hardships of armed conflicts may end up experiencing further harassment in what, from an outside perspective, should be a safe environment (6).

Many women may in war be faced with the main responsibility for care giving in the family, with the destiny of their husbands unknown and new and unfamiliar duties placed on them. If the household is facing disaster, this may

overload women's capacity to cope, as preoccupation with the needs of the family may lead to that they are not able to consider their own needs, especially if they become widows. Their means of supporting the family may be scarce and rendering sexual services may be their only way out (2). On the other hand, the care-giving role may have a protective function providing women with a natural role and identity.

Adequate medical care is seldom available in war and post-war countries. Women (as well as men and children) may suffer for years from war-induced health problems without receiving appropriate medical care (7). In some countries, as in Afghanistan, women have been prevented access to medical care (8).

Women may frequently express complaints of a somatic nature and seek help with little understanding of the psychological nature of such symptoms. Knowledge on psychotherapy may be limited and some may express a resistance to talk about psychological problems – partly because of fear of stigmatization, partly because their families may view treatment for psychological problems as non-legitimate (9).

A sustainable relation between therapist and client that will allow the client to process traumatic experiences presupposes that the therapist pays due attention to the woman's state of mind and current life situation, with gender discrimination or devalued status in society.

Cultural norms influence what is acceptable behaviour. Women who are refugees or live in war zones are frequently under severe social control, as they are expected to follow traditional patterns and show loyalty to old customs that may not coincide with their current situation and wishes. A widow, for example, may find that her behaviour is closely followed, whereas this is not the case for a widower, who experiences greater freedom of movement (10).

Therapists face a delicate balance between their wish to respect the values of the client's culture and their duty to empower the female client and support her more assertive sides in the post-war setting.

As therapists we have to keep in mind that most of us are trained in Western concepts and work in an individualistic society with emphasis on privacy and autonomy (11), while many women experiencing the atrocities of war come from sociocentric societies where persons characteristically are seen "as their role". Consequently, the failure to perform one's role as wife, mother, or daughter may be interpreted as a failure as a person.

Women's health situation is frequently characterized by a variety of problems caused by a combination of traumatic past and current stressors. In addition, women may be subjected to restrictions in their personal mobility and efforts to adapt to new roles, further adding to their disadvantage and marginalization (9).

Society has an obligation to develop services that offer culture and gender sensitive care paying respect to women's rights (12). The fact is, however, that many women experience that services may aggravate their feeling of disempowerment, due to their focus on patho-

logy and reduced functioning instead of promotion of health and recovery. If available services fit this description, women may find little relief when referred to care.

As therapists we should work for that women referred to treatment would encounter cultural competent staff that encourage empowerment, self-management and autonomy in daily activities (12).

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